FMCS FORM F-7
Revised August 96

# NOTICE TO MEDIATION AGENCIES

(See instructions on reverse)

Form Approved
OMB NO.3076-0004
Expires 8/31/98

MAIL TO: NOTICE PROCESSING UNIT
**FEDERAL MEDIATION AND CONCILIATION SERVICE**
2100 K STREET, N.W.
WASHINGTON, D.C. 20427

AND THE STATE OR TERRITORIAL MEDIATION AGENCY

**You are hereby notified that written notice of proposed termination or modification of the existing collective bargaining contract was served upon the other party to this contract and that no agreement has been reached.**

(1) IF THIS IS A HEALTH CARE INDUSTRY NOTICE
PLEASE INDICATE (MARK "X")

☐ INITIAL CONTRACT

☐ EXISTING CONTRACT

(2) (MARK "X") AND DATE(S):

| | | MO | DAY | YR |
|---|---|---|---|---|
| ☐ CONTRACT REOPENER | REOPEN DATE | | | |
| To be filled in **only** if existing contract provides for reopening for specific changes during its term **or** if voluntary reopener. | EXPIRATION DATE | | | |
| ☐ CONTRACT EXPIRATION | EXPIRATION DATE | | | |

(3) NAME OF EMPLOYER OR EMPLOYER ASSOCIATION/ORGANIZATION (IF MORE THAN ONE, SUBMIT NAMES AND ADDRESSES ON AN ATTACHED LIST)

(4) ADDRESS OF EMPLOYER/ASSOCIATION NO. STREET CITY STATE ZIP

(5) EMPLOYER OFFICIAL TO CONTACT (NAME AND TITLE)

(6 A) (AREA CODE) PHONE NUMBER

(6 B) (AREA CODE) FAX NUMBER

(7) NAME OF INTERNATIONAL UNION OR PARENT BODY

(8) NAME AND NO. OF LOCAL (IF NOT A LOCAL, GIVE NAME AND NUMBER, IF ANY, OF THE UNION ORGANIZATION INVOLVED IN THE NEGOTIATIONS)

(9) ADDRESS OF LOCAL UNION NO. STREET CITY STATE ZIP

(10) UNION OFFICIAL TO CONTACT (NAME AND TITLE)

(11 A) (AREA CODE) PHONE NUMBER

(11 B) (AREA CODE) FAX NUMBER

(12 A) LOCATION OF AFFECTED ESTABLISHMENT CITY STATE ZIP

(12 B) LOCATION OF NEGOTIATIONS CITY STATE ZIP

(13) TOTAL NUMBER EMPLOYED AT AFFECTED LOCATION(S)

(14) NUMBER OF EMPLOYEES COVERED BY THIS CONTRACT

(15) INDUSTRY AND /OR TYPE OF BUSINESS

(16) PRINCIPAL PRODUCT OR SERVICE

(17) THIS NOTICE IS FILED ON BEHALF OF (MARK "X")
☐ UNION ☐ EMPLOYER

(18) TYPE OF NEGOTIATIONS (MARK "X")
☐ SINGLE ESTABLISHMENT ☐ MULTI - PLANT
☐ AREA OR INDUSTRY WIDE ☐ MULTI - EMPLOYER
☐ OTHER (SPECIFY)

(19) TYPE OF EMPLOYEES COVERED (MARK "X" IN ALL THAT APPLY)
☐ PROFESSIONAL/TECHNICAL ☐ CLERICAL
☐ PRODUCTION/MAINTENANCE ☐ CONSTRUCTION
☐ OTHER (SPECIFY)

(20) NAME AND TITLE OF OFFICIAL FILING NOTICE

(21) SIGNATURE AND DATE

# INSTRUCTIONS FOR FILLING OUT FORM F-7

Upper Left Hand Corner:
Mail all F-7 Forms for the Federal Mediation and Conciliation Service to the address shown in this spot. There is no need to send a copy to any of our other offices.

Upper Right Hand Corner:
The State or Territorial Mediation Agency (FMCS does not forward them)

Item 1. Please check only if the employer provides Health Care Services.

Item 2. Give contract expiration date and if notice is being submitted for a contract reopener, give both. Check the one that it is being submitted for.

Item 3. Give complete name of employer. Do not use abbreviations, please spell out full name. If the employer has only abbreviations in name, please state (abbreviations only) afterward.

Items 4,5,&6. Self Explanatory.

Item7. Self explanatory. If an independent union, please spell out full name even if it repeats Line 8.

Item8. If union has been spelled out on line 7, all we need is the local number or identification.

Items 9,10,&11. Self explanatory

Item12A. If the company is at the same location as the address in Line 4, put same as above; if different, please provide information.

Item12B. Please provide information, if appropriate, All we want is your best guess of the city, state, and zip code where the negotiations will most likely occur. We do not need the motel, hotel, meeting room - only the city, state, and zip code.

Items 13&14 The numbers contained in items 13 and 14 are rarely the same; there are usually supervisors, clerical, sales and others at the same location who are not union members or are members of other unions or may be members of this union but covered under another contract.

#13 - If you are unable to estimate the total number employed at the affected locations (union and none-union combined), please leave blank rather than duplicating the information provided in line #14.

#14 - Please estimate as accurately as possible the total number of unionized members covered by this contract.

Item 15. Please provide information on the industry of the employer in line 3; not what the bargaining unit does.

Item16. Please provide information on what product or service the employer in line 3 provides; again, not what the bargaining unit does.

Item17. Please check who is filing the notice.

Item 18. Please check the block that is most appropriate.

Item 19. Please check the block that is most appropriate.
Item 20. Self explanatory.

Item 21. Self Explanatory.

Note: Receipt of this form does not constitute a request for mediation nor does it commit FMCS to offer its facilities. Receipt of this notice will not be acknowledged in writing by FMCS. FMCS does not forward copies of this notice to state or territorial mediation agencies. While the use of this form is voluntary, it will facilitate our service to respondents. Copy should be sent to appropriate State or Territorial Agency if applicable and to opposite party in negotiation; Copy should be retained by party filing notice.

PAPERWORK REDUCTION ACT NOTICE: The estimated burden associated with this collection of information is 30 minutes per respondent. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be sent to the Director, Federal Mediation and Conciliation Service (FMCS), 2100 K Street, N.W., Washington, D.C. 20427. Persons are not required to respond to this collection of information unless it displays the currently valid OMB control number.